Should an Emphasis on Community Participation be an Essential Part of All Community Level Child Survival Programs?

By

Paul Freeman

Overview

- What
- Why
- Limitations

What is it?

Ideal Characteristic of Community Participation

- Community owns the project to the extent that they contribute the local knowledge about how an intervention can be most effectively implemented in their community to produce the best health outcomes
- We provide the scientific evidence base that an intervention works but this alone is not enough to produce good outcomes locally

The What?

- Participate- starting with local capacity- in-
  - Planning- building on their existing organizations
  - Implementation- leaders, groups, organization
  - Evaluation- at an accessible local level of complexity– they collect and see how their data is used---“we” provide complexity for higher levels
  - Reporting to donors locally- “we” for higher level
  - “We” translate feedback from higher levels to community maintaining their ownership.

Good Community Participation

Requires action at as many levels as possible.

- Micro – personal, family, local groups
- Meso – local community, local government, district, provincial, cross-sector
- Macro – government and donor policy
- Developmental – movement from passive to active role in health- "What we do matters!"
- (Early Adaptors – see Raj & Mable Arole)

Sustainable Development Requires Action Learning

- *"Development can be neither given nor received; it must be generated from within."*

- *"What the less developed have been most deprived of is not the fruits of development, but the opportunity to develop themselves."*
-

Ref: "*Systems Thinking"* Jamshid Gharajedaghi

Why is Good Community Participation Essential ?

- There is evidence that it works → best results
- Lasting internalization and practice of health behavior change only comes about when community members own the change
- History – donors, governments move on and may well continue to do so.
- Technology promising but affordability, access?
- The biggest resource for > 2,000,000,000 people is themselves ACTIVE.

Evidence from a Recent Review

As part of a broader evidence summit USAID and UNICEF convened a large literature review of effective means to empower communities to achieve behavioral and social changes.

Farnsworth, Bos , Olaoluwa et al (2014) identified 34 documents from 18 countries that met their eligibility criteria and concluded that programs

- **" working collaboratively or achieving shared leadership with a community can lead to behavior change and cost-effective sustained transformation to improve critical health behaviors and reduce poor health outcomes" in low- and middle-income countries.**

- **across a range of areas from reduced neonatal mortality rates to improved nutritional status.**

S. K Farnsworth, K. Bose, Olaoluwa, P. P. Souza, A. Peniston, L. L Davidson, M. Griffiths, S. Hodgins(2014) Community Engagement to Enhance Child Survival and Early Development in Low- and Middle-Income Countries: An Evidence Review, *Journal of Health Communication:* International Perspectives, 19;supl,67-88

Systematic Review of the Effectiveness of Community-Based Primary Health Care in Improving Child Health*.

Findings about specific interventions at Community

- Types of studies-

  balance of the evidence → causality
- Effectiveness (real world)
- Case Control --- ideal situations, compliance
- Observational – no control but if repeated ??
- Grey Literature – lack of rigor, bias, placebo effects (up t0 30% of apparent effect)

- Perry.H, Freeman.P, Gupta.S, Rassekh.B Systematic Review of the Effectiveness of Community-Based Primary Health Care in Improving Child Health.

Individual Studies of Childhood Pneumonia Prevention and Treatment

Site	Authors
Narangwal (rural Punjab), north India	McCord and Kielmann 1978
Bagamoyo District, Tanzania,	Mtango and Neuvians (1986)
Rural Haryana, India	Datta et al., 1987
Kathmandu Valley, Nepal	Pandey et al., 1989
Gadchiroli, India	Bang et al., 1990*, 1993, 1994
Rural villages, Pakistan	Khan 1990
Matlab, Bangladesh	Fauveau et al., 1992
Kediri subdistrict, Indonesia	Roesin et al., 1990
Jumla District of Nepal	Pandey et al., 1991
Kenya	Wafula, 2000
Matlab, Bangladesh	Aliet al., 2001
Urban slum of Delhi, India	Bhandari et al., 2002b
northern Bangladesh	Hadi, 2003

EOP Evaluation of BASICS iCCM Project Benin 2009 to 2012

200,000 Children < 5 years. 15% of Benin population, 5 Health Zones

USAID funded MSH implemented

Case Control and Skill Observation Methodology

Freeman Paul

Deussom Gabriel

Paraïso M Noël

Glèlè Yolaine

Benin & Interventions

Francophone
Traditional Muslim
Life E at B 56.8yrs
Fertility 5.1 c/w
IMR 73/1000
CMR 115/1000
2012
Malaria, ARI, diarrhea
47% < 5s stunted

- iCCM per CHWs rural villages > 5 km from H. F.
- CHWs home visits – ed + link with local HFs
- Community based information system→ HCs
- Local NGOs support CHWs –ESP remote areas

Results

CHW Coverage Level by Health Zone						
	Banikoara	Bassila	D-C-O	K-G-S	Tchaourou	Total
Total villages (>5kms)	462	104	472	348	330	1716
Covered Villages (>5kms)	181	54	250	147	109	741
RC/HZ trained	186	108	360	223	172	1049
% coverage	39%	50%	69%	42%	33%	43%

Source: Project Data, January 2011, BASICS.

Case Control General

Interviews with standardized forms

Intervention area 300 Mothers in 30 clusters

Control area 300 Mothers in 30 clusters

Control area in south of Benin, similar demography and maternal education.

- 236 mothers sought HC for child from CHW in intervention area c/w 108 who sought HC from CHW in control

Person/s Approached for Initial Care

	INTERVENTION	CONTROL	TOTAL
CHW	240 (78.7%)	108 (36.2%)	348 (57.7%)
Health Center	26 (8.5%)	95 (31.9%)	121 (20.0%)
Local Store	15 (4.9%)	82 (27.5%)	97 (16.0%)
Traditional Practitioner	4 (1.3%)	9 (3.0%)	13 (2.1%)
Parent/Friend	20 (6.6%)	4 (1.4%)	4 (0.7%)
	305 (100%)	298 (100%)	603

Time Delay Before Seeking Health Care In Intervention And Control Areas

	INTERVENTION	CONTROL	
Delay in seeking health care			
Less than 12 hours	117 (49.6%)	11 (10.2%)	128
12 to 24 hours	77 (32.6%)	36 (33.3%)	113
24 to 48 hours	25 (10.6%)	46 (42.6%)	71
More than 48 hours	17 (7.2%)	15 (13.9%)	32
N	236 (100%)	108 (100%)	344

Use Of Health Care BEFORE The Presence Of iCCM local CHW Compared With Control

Initial Source of health care		INTERVENTION	CONTROL	Total	
Health Center		147 (61.2%)	86 (79.63%)	223 (66.95%	P = 0.000
Self-Medication		67 (27.92%)	43 (39.81%)	110 (31.16%	P = 0.027
Traditional Practitioner		3 (1.2%	10 (9.3%)	13 (3.7%)	P = 0.000
	N	240 (100%)	108 (100%)	348	

Mother's perception of the quality of care given by CHW

PERCEPTION	INTERVENTION	CONTROL
Correct treatment given by CHW	90.5%	70.3%
Satisfied with health care given	97.5%	87%
Access to follow up health care valued	50%	23.1%

Community Participation

- Communities chose those who were to be the local iCCM care deliverers---older males
- Local NGOs motivated supported CHWs
- CHWs – said main motivation – internal
- Basic remuneration came later per local govt.

- Skills of CHW maintained per local community

Local NGO members

Osanzaya Zambezia

5 year project in poor rural Mozambique, 2013

Large remote population, few health facilities.

Goal: **To Reduce Food Insecurity in Targeted Five Districts in Zambézia Province.**

- **SO1: Improved Income Growth of 37,500 Rural Beneficiaries**
  By integrating marketing, increased productivity, and strengthened value chains of select agriculture products
- **SO2: Improved Health and Nutrition Status for 40,000 Beneficiaries**
  By improved health and nutrition status of children under five, improved hygiene behaviors, access to sanitation solutions, and adequate clean water.
- Literacy & Disaster Preparedness (ADPP & Samaritan's Purse)

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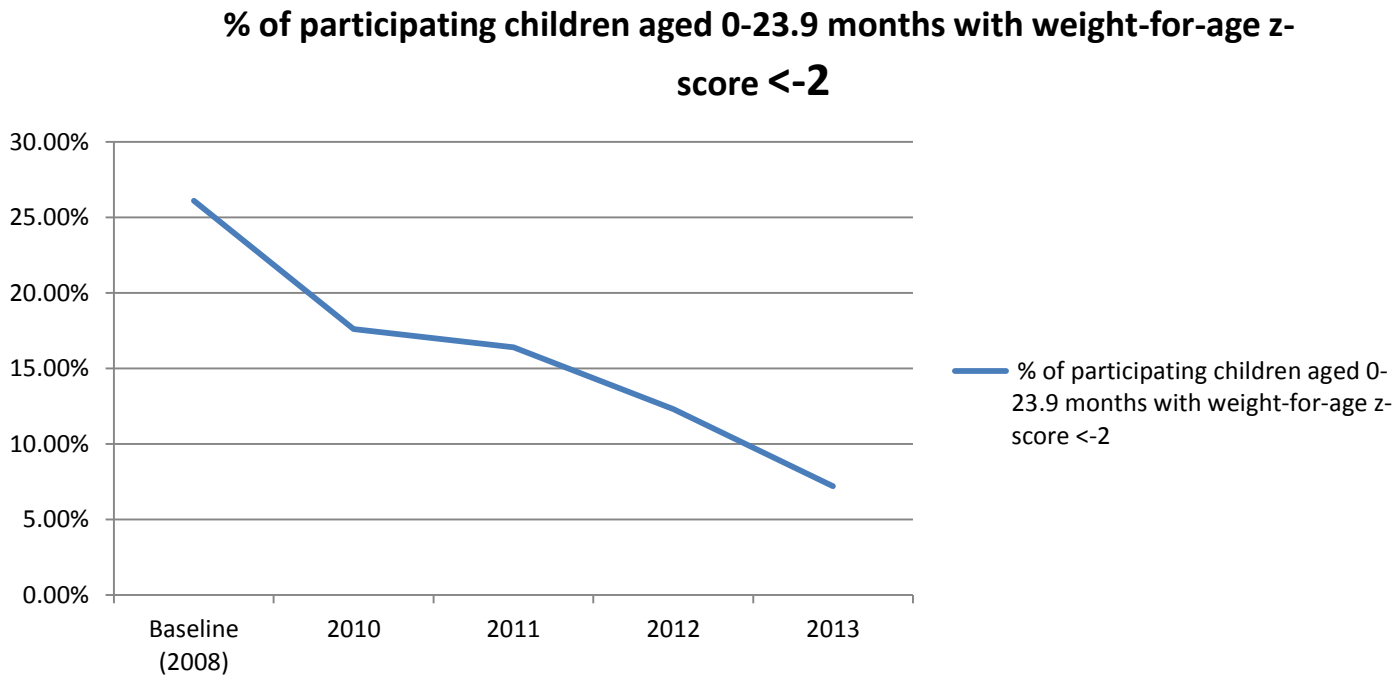
Overall Health Activities

- Established and strengthened Community Leadership Councils
- Established mothers' and fathers' groups
- Cooking/feeding sessions
- Constructed and rehabilitated boreholes and wells
- Constructed household and community latrines
- Monthly GMP
- Participatory Hygiene and Sanitation Transformation (PHAST)
- Behavior Change Communication
  - hygiene, diet diversification, food preparation, breastfeeding, disease prevention, health-seeking and caregiving behaviors

KEY FINDINGS

Figure 1. Decrease in Portion of Severely Malnourished



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KEY FINDINGS

INDICATOR	BASELINE	FINAL	DIFFERENCE
% of children less than 24 months with diarrhea in the past 2 weeks"	33.8%	28.6%	**5.2%**
% of caregivers and food preparers using appropriate hand-washing behavior	56.9%	80.6%	**23.7%**
% target population using latrines	29.4%	53.8%	**24.4%**
% target population with year round access to improved water source	23.3%	56.70%	**33.4%**

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Community Leadership Councils

Each have about 25 members that include:

- Community leadership/elders
- Community health volunteers (1 per 15HH)
- Hygiene promoters
- Mothers' and Fathers' group leaders
- Water Well Committee members
- C- IMCI workers
- FP/STI counselors
- Home-based care workers
- Midwives
- Traditional birth attendants

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Community Leadership Councils

- Meet at least every two weeks plan, implement, evaluate together
- Mitigate health issues in communities including emergencies
- Receive feedback and reports from all CHWs of their activities
- Representatives (2) meet with local HC staff once a month
- Identify community members with special needs
  - Usually done via group counseling sessions and household visitation
- Supervised by project staff , Post project HC staff 10-20 miles away

THESE WERE BASIC LEARNING ORGANIZATIONS

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Some Characteristics of a Learning Organization (after Senge)

- Common Vision- healthy community.
- Team Learning- together we can master
  - An appreciation that the different members of the group contribute different skills and capacities. Technical expert help is needed but community members contribute local knowledge and skills that health professionals cannot.
- Personal Mastery-personal capacity growth sought and nourished / motivation (inner purpose- after Pink "Drive")
- Mental Models – " together we can do this".
- Move away from passivity

EOP evaluation of the ENRICH Project Rural Cambodia 2010-2014

Target population 106,166 49,372 women (15-49 years) and 12, 847 children < 5 years 138 villages

2010

IMR 45/1000 LB U5M 54/1000 U5 s 40% Stunted

48% of mothers delivered in a health facility

38% used modern contraceptives.

ENRICH- Evidence-based Interventions for Improved Nutrition to Reinforce Infant, Child and Maternal Health.

ENRICH PROJECT COMPONENTS

- Integrated Approach
  - Use of community members as change agents
  - Link to the community with Village H Volunteers
  - Whole family approach –mothers & fathers group
  - “PD Hearth Approach” -> from 30 to all 138 villages
  - Use of “edutainment”
  - Message saturation
  - Promotion of vegetable & fruit gardens
  - Safe water supplies

COMPARISON OF BASELINE AND ENDINE RAPID CATCH INDICATORS

Project Rapid Catch Indicators	Base(%)	Endline (%)	Diff %	Signif. Cis
% of children age 0-23 months ---underweight (-2 SD mwfa)	22.2	12.7	9.5	Not Significant
-who are stunted (-2 SD mhfa)*	32.7	17.2	15.5	Significant
--with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or home fluids	21.4	53.6	32.2	Significant
---with a febrile episode in the last two weeks who were taken to an appropriate health provider	57.8	81.3	23.5	Significant
--- who slept under an insecticide-treated bed net the previous night	22.7	91.3	68.6	Significant

COMPARISON OF BASELINE AND ENDINE RAPID CATCH INDICATORS

Project Rapid Catch Indicators	Base (%)	Endline (%)	Diff %	Sign CIs
Percentage of mothers of children age 0-23 months who had four or more antenatal visits when they were pregnant with the youngest child	66.7	83.3	16.6	Significant
Percentage of children 0-23 months whose births were attended by skilled personnel	89.0	95.3	6.3	Significant
Percentage of mothers of children age 0-23 months who are using a modern contraceptive method	20.7	79.1	58.4	Significant

ENRICH Community Involvement

- A culturally appropriate approach to community engagement using and respecting existing community structures ,involving community at all stages incl evaluation-

- Using community members and existing leaders(Village Chiefs, Monks) as change agents- mass meetings, groups , household visiting.

- Use of a family centered approach involving men and women;
- Building the key BCC messages around behavior change research with men and women; adaptation on feedback from community. Use of message saturation.
- Mothers became the key organizers of community feeding groups.
- Involving the MOH HC staff as partners at all stages.

Erin Meyer writes that the important points for cross cultural communication are "putting yourself in their shoes"; being humble and curious or showing a general interest in those you wish to communicate with cross-culturally.

Erin Mayer 2014 The Cultural Map. Breaking through the invisible boundaries of global business. Public Affairs.

Limitations

- Takes time and committed facilitators
- Attitude is everything

  Need to change attitude of all involved?
- Resource constraints may be a problem
- Supervision and ongoing facilitation
- Key implementers – are trained motivated project & DOH staff in regular contact with communities
- Supportive Policies & Evidenced-base Research

Thank You

Follow on for references, resources.

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